Medical Examination Report

Michigan Department of State
Driver Programs Division
Lansing, MI 48918
Phone: 517-241-6850

Please check the appropriate box.

☐ Driver Training Schools Program

☐ Third Party Testing Program

INSTRUCTIONS FOR APPLICANT: A Medical Examination Report completed by a physician, a physician's assistant, or a certified nurse practitioner licensed to practice in this state must be submitted to the Department of State's Driver Programs Division and updated every two years. The medical information provided could be used to request an assessment of your driving privileges. Please complete the 'Release of Information' below before presenting the form to a physician, physician's assistant, or certified nurse practitioner.

RELEASE OF INFORMATION	I authorize and request information regarding my physical condition be released to the Department of State. I understand that the information provided may prompt an evaluation of my ability to operate a motor vehicle safely. _____ _____ Name (Print) Signature Date

INSTRUCTIONS FOR PHYSICIAN, PHYSICIAN'S ASSISTANT, OR CERTIFIED NURSE PRACTITIONER: The patient for whom you are completing this report has submitted an application to the Department of State for licensure as a driver training school instructor or to become a driving skills test examiner. Your answers, and any additional information you feel is pertinent, will aid this office in determining whether the applicant is physically able to operate a motor vehicle safely as well as instruct or test others in the operation of a motor vehicle. Medical Examination Reports must be based on an **examination that was completed within six weeks** of the date on the form.

A. Does the above applicant have any of the following (check the ones applicable):

- ☐ Disease causing impairment, loss of consciousness, or confusion
- ☐ Limiting or progressive neurological or neuromuscular disease
- ☐ Diabetes or other metabolic disorder
- ☐ Atherosclerosis/heart disease
- ☐ Limitation of movement or use (or loss) of a foot, leg, or arm
- ☐ Respiratory dysfunction
- ☐ Anxiety
- ☐ Depression
- ☐ Poorly Controlled Anger

B. If any of the above boxes are checked, in your opinion would the condition interfere with safe driving or in providing instruction or administering a road test to others? .. .. ☐ Yes ☐ No

Please explain: _____

_____

_____

C. Does the patient have any clinical evidence or do you have personal knowledge of your patient's addictions to or the habitual use of drugs, alcohol, or other drugs? .. .. ☐ Yes ☐ No

If yes, indicate the addiction and the duration of the addiction _____

Is the patient currently under treatment for the addiction? .. .. ☐ Yes ☐ No

---

I certify that I am a physician, physician's assistant, or a certified nurse practitioner, and the statements contained in this report are true to the best of my knowledge and belief.

Signature _____ Name (Print) _____ Date _____

Address (Street, City) _____

Phone _____ License Number _____ Type of Practice _____